SENATE BILL No. 634

Introduced by Senator Speier

February 22, 2005

An act to add Section 10133.66 to the Insurance Code, relating to health insurance.

LEGISLATIVE COUNSEL'S DIGEST

SB 634, as introduced, Speier. Health insurance: claims practices.

Existing law provides for regulation of health care service plans by the Department of Managed Health Care and regulation of health insurers by the Insurance Commissioner. Existing law, known as the Health Care Providers Bill of Rights, imposes certain requirements and prohibitions on the relationship between providers of health care services and health insurers relative to alternative rates of payment made by insurers on behalf of covered insureds.

This bill would impose additional requirements on health insurers that enter into contracts with health care providers relative to the processing and payment of claims.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) The billing by providers and the handling of claims by insurers are essential components of the health care delivery process.

(b) Health maintenance organizations and preferred provider organizations regulated by the Department of Managed Health Care are subject to regulations to prevent unfair payment

practices against health care providers. Preferred provider organizations and other entities regulated by the Department of Insurance are not subject to many of these regulations, leaving providers and their patients without similar protections.

(c) To ensure the appropriate payment of claims and consistent regulation of overpayment of health care services by third-party payors, this act extends many of the current protections afforded by the Legislature to providers who deliver care to health care service plan enrollees to those who deliver care to insureds.

SEC. 2. Section 10133.66 is added to the Insurance Code, to read:

10133.66. A health insurer that enters into contracts with a professional provider to provide services at alternative rates of payment pursuant to Section 10133, whether directly or through any entity that contracts with providers on its behalf, shall comply with all the following:

(a) Deadlines shall not be imposed for the receipt of a claim that is less than 90 days for contracted providers and 180 days for noncontracted providers after the date of service, except as required by any state or federal law or regulation. If a health insurer is not the primary payor under coordination of benefits, the insurer shall not impose a deadline for submitting supplemental or coordination of benefits claims to any secondary payor that is less than 90 days from the date of payment or date of contest, denial, or notice from the primary payor. A health insurer, whether directly or through any entity that contracts with providers on its behalf, that denies a claim because it was filed beyond the claim filing deadline shall, upon provider's demonstration of good cause for the delay, accept and adjudicate the claim according to Section 10123.13 or 10123.147, whichever is applicable.

(b) Reimbursement requests for the overpayment of a claim shall not be made, including requests made pursuant to Section 10123.145, unless a written request for reimbursement is sent to the provider within 365 days of the date of payment on the overpaid claim. The written notice shall clearly identify the claim, the name of the patient, and the date of service, and shall include a clear explanation of the basis upon which it is believed the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim. The 365-day time

limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider.

(c) The receipt of each claim shall be identified and acknowledged, whether or not complete, and the recorded date of receipt shall be disclosed in the same manner as the claim was submitted or provided through an electronic means, by telephone, Web site, or another mutually agreeable accessible method of notification, by which the provider may readily confirm the insurer's receipt of the claim and the recorded date of receipt as follows:

(1) In the case of an electronic claim, identification and acknowledgment shall be provided within two working days of the date of receipt of the claim by the office designated to receive the claim.

(2) In the case of a paper claim, identification and acknowledgment shall be provided within 15 working days of the date of receipt of the claim by the office designated to receive the claim.

If a claimant submits a claim to a health insurer, or any entity that contracts with providers on its behalf, using a claims clearinghouse, its identification and acknowledgment to the clearinghouse within the timeframes set forth in paragraph (1) or (2), whichever is applicable, shall constitute compliance with this section.

(d) Beginning January 1, 2006, initially upon contracting, annually thereafter on or before the contract anniversary date, and in addition, upon the contracted provider's written request, the health insurer or the entity that contracts with providers shall disclose to contracting providers all of the following information in an electronic format:

(1) The amount of payment for each service to be provided under the contract, including any fee schedules or other factors or units used in determining the fees for each service, shall be disclosed on the Internet or on written request by the health insurer or the entity that contracts with providers. To the extent that reimbursement is made pursuant to a specified fee schedule, the contract shall incorporate that fee schedule by reference, including the year of the schedule. For any proprietary fee schedule, the contract shall include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

(2) The detailed payment policies and rules and nonstandard coding methodologies used to adjudicate claims, that shall, unless otherwise prohibited by state law do all of the following:

(A) When available, be consistent with Current Procedural Terminology (CPT), and standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies, and major credentialing organizations.

(B) Clearly and accurately state what is covered by any global payment provisions for both professional and institutional services, any global payment provisions for all services necessary as part of a course of treatment in an institutional setting, and any other global arrangements such as per diem hospital payments.

(C) At a minimum, clearly and accurately state the policies regarding all of the following:

(i) Consolidation of multiple services or charges, and payment adjustments due to coding changes.

(ii)Reimbursement for multiple procedures.

(iii) Reimbursement for assistant surgeons.

(iv) Reimbursement for the administration of immunizations and injectable medications.

(v) Recognition of CPT modifiers.

The information disclosures required by this section shall be in sufficient detail and in an understandable format that does not disclose proprietary trade secret information or violate copyright law or patented processes, so that a reasonable person with sufficient training, experience, and competence in claims processing can determine the payment to be made according to the terms of the contract.

A health insurer, whether directly or through any entity that contracts with providers on its behalf, may disclose the fee schedules mandated by this section through the use of a Web site so long as it provides written notice to the contracted provider at least 45 days prior to implementing a Web site transmission format or posting any changes to the information on the Web site.

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